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Circular Letter: DHCQ 15-10-643

TO: Chief Executive Officers, Non-Acute Care Hospital

FROM: Eric Sheehan, JD
Interim Bureau Director of Health Care Safety and Quality

SUBJECT: Guidelines for Reporting Use of Electronic Health Records and Computerized Provider Order Entry for Non-Acute Care Hospitals

DATE: October 1, 2015

Sections 36 and 37 of Chapter 305 of the Acts of 2008, *An Act to Promote Cost Containment, Transparency and Efficiency in the Delivery of Quality Health Care,* requires hospitals and community health centers to implement certified electronic health records (EHR) and computerized physician order entry (CPOE) systems as a condition of licensure. The Department promulgated regulations pursuant to this requirement in June of 2013, which can be found at 105 CMR 130.375 (Attachment B).

This circular letter outlines the regulatory requirements for non-acute care hospitals and the steps that these facilities must take to be considered in compliance as of October 1, 2015. While the Department expects that all non-acute care hospitals will have implemented EHR technology and CPOE systems by October 1, 2015, in light of the timing of the release of this guideline, the Department will presume implementation, and we will delay confirmation of compliance with this implementation by non-acute care hospitals, provided that they submit documentation of compliance or a waiver request, as set forth below, no later than November 15, 2015.

Non-acute care hospitals must demonstrate compliance with two requirements in 2015. These include:

1. Implementation of certified EHR Technology, as specified in 45 CFR Part 170 and in guidelines of the Department; and

2. Utilization of CPOE, as specified in guidelines of the Department.

Non-acute care hospitals must implement CPOE systems and EHR technology that are certified by an agency or organization established for the purpose of certifying that the system or technology meets national interoperability standards. To demonstrate compliance with this requirement, non-acute hospitals must submit documentation that they have implemented EHR technology and a CPOE system, and that each has been certified by one of the certification bodies accredited by the American National Standards Institute (ANSI), the Approved Accreditor for the Office of the National Coordinator (ONC) Permanent Certification Program of Health Information Technology, including identification of the specific certifying body that certified the non-acute hospital's EHR technology and the CPOE system.

Non-acute care hospitals must submit this documentation through the Health Care Facilities Reporting System (HCFRS). Detailed instructions for reporting through HCFRS are included below.

Non-acute care hospitals that are not able to submit documentation of compliance by November 15, 2015, may apply for a waiver under 105 CMR 130.050 by November 15, 2015. To apply for a waiver, a non-acute care hospital should submit a written letter to the Department addressing the following items:

1. The specific requirement(s) in 105 CMR 130.375 that the non-acute care hospital requests be waived (1 or 2 above);

2. The non-acute care hospital's current progress in implementing EHR/CPOE systems and meeting the requirements outlined in 105 CMR 130.375;

3. The circumstances leading the non-acute care hospital to request the waiver;

4. The date by which the non-acute care hospital expects to be in compliance with the requirements; and

5. The measures that the non-acute care hospital has taken to ensure that its inability to meet the requirements is not jeopardizing patient safety or quality of care.

NOTE: A non-acute care hospital that has received a waiver is still required to report its compliance status using the HCFRS and, upon achieving compliance, file a report with the Department through HCFRS, indicating that it has achieved compliance.

If you have any questions about this guidance, please contact the Bureau of Health Care Safety and Quality, Office of Policy and Quality Improvement, at lauren.nelson@state.ma.us.

Attachment A

Guidelines for Submitting Documentation of Compliance with 105 CMR 130.375

Documentation: All non-acute care hospitals must submit to the Department Documentation of Compliance, consisting of the Verification of Certification issued by a specified certifying body. The Documentation must identify the certifying body used by the non-acute care hospital.

Timeline: Hospitals must submit Documentation of Compliance by November 15, 2015.

Format: Hospitals must submit the documents using the Health Care Facility Reporting System (HCFRS) using the same online form that hospitals use to report incidents, Serious Reportable Events and Mandatory Nurse Overtime.

NOTE: HCFRS can only be accessed by authorized users. Instructions on enrolling a new user in HCFRS are available online at: http://www.mass.gov/eohhs/provider/reporting-to-state/abuse-neglect/health-care-facilities/forms-and-web-based-reporting.html

Hospitals may also submit the Documentation under the account of an existing user. Please do not call the Department to inquire about which individuals at your facility are authorized users; the Department does not keep updated records of this information.

NOTE: All hospitals were required to enroll in HCFRS by June 30, 2013, per circular letter number DHCQ 13-4-588. No hospital is authorized to submit its Documentation by fax or mail.

Steps:
To submit your hospital's Documentation to the Department, please complete the following steps:

1. Become certified by an accrediting body and obtain verification.

2. Log-in to HCFRS to create a new report at: https://gateway.hhs.state.ma.us/authn/login.do

3. Complete the Reporter Information section.

4. When asked to "enter a patient/resident/client" in the Patient Information Section, select "No". No other information should be completed in this section.

5. In the Incident Information section, complete the following fields:

a. Incident Date: Please enter the date on which you are submitting the report.

b. Select the Incident Type: EHR/CPOE

c. Leave all other the other fields in the Incident Information field blank, except for the Incident Narrative field.

d. In the Incident Narrative field, please enter the appropriate text, choosing from the options below:

   i. EHR/CPOE documentation is attached to this report; or

   ii. Hospital has been granted a waiver for this reporting period.

   If neither of the options above is accurate for your hospital, please contact Deb Ulin, Quality Improvement Coordinator for Survey and Certification at debbie.ulin@state.ma.us.

e. Leave the Notification, Witness Information and Accused Information sections blank.

f. Scan the Verification of Certification and attach the PDF.

g. Submit your report.

Attachment B

130.375: Electronic Health Records

(A) Definitions applicable to 105 CMR 130.375

Acute Hospital means a hospital with a majority of medical-surgical, pediatric, obstetric, and maternity beds, as defined by the Department.

Centers for Medicare & Medicaid Services (CMS) means the agency within the federal Department of Health and Human Services responsible for administering Medicare, Medicaid, and the Children's Health Insurance Program.

Certification Commission for Healthcare Information Technology (CCHIT) means the nonprofit organization authorized by the Office of the National Coordinator for Health Information Technology to test and certify EHR technology to the certification criteria specified in 45 CFR Part 170.

Certified Electronic Health Record (Certified EHR) Technology means EHR technology that has been tested and certified by CCHIT or another agency or organization approved by ONC-HIT to test and certify EHR technology.

CMS Stage 1 Meaningful Use Criteria means the Stage 1 meaningful use objectives and measures specified in 42 CFR Part 495.

CMS Stage 2 Meaningful Use Criteria means the Stage 2 meaningful use objectives and measures specified in 42 CFR Part 495.

Computerized Provider Order Entry (CPOE) means a system that enables the provider to directly enter medication orders, laboratory orders, and radiology orders from a computer or other electronic device. The order is then documented or captured in a digital, structured, and computable format for use in improving the safety and efficiency of the ordering process.

Electronic Health Record (EHR) Technology means computer technology that records patient health-related information and:

(1) includes patient demographic and clinical health information, such as medical history and problem lists;

(2) has the capacity to:

(a) provide clinical decision support;

(b) support provider order entry;

(c) capture and query information relevant to health care quality;

(d) exchange electronic health information with, and integrate such information from other sources;

(e) protect the confidentiality, integrity and availability of health information stored and exchanged.

Eligible Professional (EP) means an eligible professional as defined in 42 CFR 495.100 or a Medicaid eligible professional as defined in 42 CFR 495.304.

Non-acute Hospital means a hospital licensed under 105 CMR 130.000 that is not an acute hospital.

Office of the National Coordinator for Health Information Technology (ONC-HIT) means the agency within the federal Department of Health and Human Services responsible for authorizing organizations to test and certify EHR technology to the certification criteria specified in 45 CFR Part 170.

Satellite Community Health Center (SCHC) means a satellite unit of a hospital that also is a federally-qualified health center operating in conformance with federal rules for community health centers at 42 U.S.C. 254b and currently participating in the Massachusetts Medicaid program, or a community health center with an active provider agreement with MassHealth under 130 CMR 405.000: *Community Health Center Services*.

2011 Edition EHR Certification Criteria means the 2011 EHR certification criteria specified in 45 CFR Part 170.

2014 Edition EHR Certification Criteria means the 2014 EHR certification criteria specified in 45 CFR Part 170.

(B) Implementation of Certified Electronic Health Record Technology in Hospitals.

(1) A hospital shall provide documentation to the Department demonstrating that it has implemented Certified Electronic Health Record Technology and that it utilizes CPOE, as specified in 105 CMR 130.375 and in guidelines of the Department.

(2) A hospital shall submit data regarding its implementation and use of Certified EHR Technology, as specified in guidelines of the Department.

(3) Acute Hospitals.

(a) No later than December 1, 2013, an acute hospital shall:

1. implement Certified EHR Technology that has been tested and certified to comply with *2011 Edition EHR Certification Criteria*;

2. register with CMS and attest to compliance with CMS Stage 1 Meaningful Use Criteria; and

3. utilize CPOE for at least 30% of medication orders, as specified in 42 CFR Part 495 and in guidelines of the Department.

(b) No later than December 1, 2015, an acute hospital shall:

1. implement Certified EHR Technology that has been tested and certified to comply with *2014 Edition EHR Certification Criteria*;

2. register and attest to compliance with CMS Meaningful Use Criteria, as specified in guidelines of the Department; and

3. utilize CPOE for at least 60% of medication, 30% of laboratory and 30% of radiology orders, as specified in 42 CFR Part 495 and guidelines of the Department.

(c) Beginning in 2015, an acute hospital shall report to the Department annually whether it is subject to CMS downward payment adjustments, as described in 42 CFR 412.64 or 495.211, resulting from failure to meet meaningful use criteria, as specified in guidelines of the Department.

(4) Non-acute hospitals.

(a) No later than October 1, 2015, a non-acute hospital shall:

1. implement Certified EHR Technology, as specified in 45 CFR Part 170 and in guidelines of the Department; and

2. utilize CPOE, as specified in guidelines of the Department.

(5) Documentation of Meaningful Use.

(a) A hospital shall, upon request of the Department, submit documentation to the Department pertaining to the hospital's use of Certified EHR Technology, Medicare payment adjustments, and CMS registration and attestation, as specified in guidelines of the Department.

(b) A hospital shall keep documentation supporting its demonstration of meaningful use for six years following the EHR reporting period, as defined in 42 CFR 495.4.

(C) Implementation of Certified EHR Technology in Satellite Community Health Centers.

(1) A hospital licensed to operate a Satellite Community Health Center shall provide documentation to the Department demonstrating that the SCHC has implemented Certified EHR Technology, that its eligible professionals have registered with CMS and attested to compliance with CMS EHR Meaningful Use Criteria, and that it utilizes CPOE, as specified in 105 CMR 130.375 and in guidelines of the Department.

(2) No later than October 1, 2016, an SCHC shall:

(a) implement Certified EHR Technology, as specified in 45 CFR Part 170 and in guidelines of the Department;

(b) attest that at least 70% of eligible professionals employed by the SCHC have registered with CMS and attested to compliance with CMS Stage 1 meaningful use criteria, as specified in guidelines of the Department; and

(c) utilize CPOE, as specified in guidelines of the Department.

(3) After October 1, 2016 the Department may require that a higher percentage of eligible professionals employed by the SCHC register with CMS, attest to compliance with CMS EHR meaningful use criteria, and utilize CPOE as specified in guidelines of the Department.

(4) Review of Meaningful Use.

(a) A SCHC shall, upon request of the Department, submit documentation to the Department pertaining to its use of Certified EHR Technology and meaningful use by eligible professionals, as specified in guidelines of the Department.

(b) A SCHC shall keep documentation supporting its eligible professionals' demonstration of meaningful use for six years following the EHR reporting period, as defined in 42 CFR 495.4.